

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037195

FILED VS OCT 23 1959

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 118

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ft Leonard Wood, Mo</u>		Length of stay in 1b <u>32 hrs</u>		c. CITY OR TOWN <u>Ft Leonard Wood, Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>US Army Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>US Army Hospital</u>		
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Female</u> Last <u>Spears</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>14</u> Year <u>59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12 Oct 59</u>	
				9. AGE (last birthday)		IF UNDER 1 YEAR Months _____ Days _____	
						IF UNDER 24 HR Hours <u>8</u> Mins <u>21</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			11. BIRTHPLACE (City and state or country) <u>Ft Leonard Wood, Mo</u>	
						12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret A. Spears</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Margaret A. Spears</u> Address <u>Ft Leonard Wood, Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u>							INTERVAL BETWEEN ONSET AND DEATH <u>32 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Prematurity</u>							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>12 Oct 59</u> to <u>14 Oct 59</u> and last saw ^{her} _{him} alive on <u>14 Oct 59</u> Death occurred at <u>3:50 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Edward T. Barber, Capt, MC</u>				22b. ADDRESS <u>US Army Hospital Ft Leonard Wood, Mo</u>			22c. DATE SIGNED <u>15 Oct 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-15-59</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Crocker Memorial Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Crocker, Missouri</u>		
24. FUNERAL DIRECTOR <u>Hedges Funeral Homes Inc</u> ADDRESS <u>Crocker, Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>10-15-59</u>		26. REGISTRAR'S SIGNATURE <u>Carl Gray Anderson</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Clarence Moser

Licensed Embalmer No. 4896

P. O. Address Waynesville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.